MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE - PUBLIC HEALTH SERVICES

DIVISION OF DRUG CONTROL REGISTRATION FOR CONTROLLED DANGEROUS SUBSTANCES (CDS)

4201 Patterson Avenue – 5th Fl., Baltimore, Maryland 21215

DDC Website: http://dhmh.maryland.gov/laboratories/drugcont ◘ DDC Email: MDDC@Maryland.Gov

Main Office: (410) 764-2890 ◘ Fax: (410) 358-1793 ◘ Customer Service: (410) 764-5910, (410) 764-7980, (410) 764-4159

PRACTITIONER APPLICATION	3-YEAR CDS REGISTRATION/CERTIFICATION	CDS #:

FOR OFFICE USE ONLY: APPLICATION AUDIT CONTROL SECTION	**Processor Initials: _____** Date:____/_____/____ **Note:**	**Do Not Write In This Section..**

SEE INSTRUCTIONS ATTACHED. TYPE ENTRIES IN SECTIONS 1, 2 AND 3 BELOW. SIGN, DATE APPLICATION AND INCLUDE PAYMENT. INCOMPLETE APPLICATIONS WILL BE RETURNED AND DELAYS CDS ISSUANCE. AS NOTED BELOW, UPDATED DELEGATION AGREEMENT AND RESEARCHER QUESTIONNAIRE REQUIRED, AS WELL AS OTHER DOCUMENTATION AS LISTED IN THE ATTACHED INSTRUCTIONS. EMAIL ADDRESS REQUIRED FOR RENEWAL NOTIFICATION.* KEEP COPY OF APPLICATION FOR YOUR RECORDS.

SECTION 1: APPLICATION CLASSIFICATION, TYPE, PAYMENT AND FEE EXEMPT DETAILS

A. CLASSIFICATION-Select ☑ Profession: □MD □DDS □DMD □DO □DPM □DVM □VMD □CRNP □CNM □EMS/Med.Dir. □PA – Insert name of Physician or attach Updated Delegation Agreement (_____Required) □Researcher Schedule I (Prior DEA approval) □Researcher Schedules II, III, IV, V (Researchers must submit a Researcher Questionnaire.) See instructions for other documentations required. Lawful registration requires separate application for each Profession.

B. FEE PAYMENT DETAILS		FOR OFFICE USE ONLY	C. FEE EXEMPT DETAILS FOR GOVERNMENT AGENCIES	
(Fee Payable to DHMH-Drug Control)		App. Receive Date: / /	***CHECK TYPE:*** □ ***State*** □ ***Local*** ***(Agency Unit Code:)***	
TYPE	***FEE***	Deposit Date: / /	Agency/Institution name	
Renewal**	□ $120	Check/Mo #:	Division/Department	
New	□ $120	Processor Initials:	Agency/Institution business address	
Address Change Only	□ $50	**Do not write in this section.**	Contact Telephone #	
Name Change Only	□ $50		Print Certifier name	
Duplicate CDS Permit	□ $30		Title of Certifier	
Discontinuation (List Reason):	□ $0		Date : / /	(Signature of Certifier)
(Fees are Non-Refundable.)				

****No fee for name/address change at time of renewal.**

SECTION 2: APPLICANT DETAILS

A. Name (**print**)	(First)
	(Middle)
	(Last)
B. Business Name	
Business Street Address	
City/County/State/Zip	
C. Mailing Address	
City/State/Zip	
D. Home Address	
City/State/Zip	
E. Telephone Nos.	Business:
	Fax No.:
	Alternate or Cell:
F. Email* **(Required)**	

SECTION 3: PROFESSIONAL LICENSE DETAILS

A. Professional License #: Expiration Date: / /

B. Federal DEA #: Expiration Date: / /

C. Social Security or Tax #:

D. Is your professional license currently or has it ever been denied, suspended, restricted, revoked reprimanded or placed on probation? **□Yes □ No**

E. Is your license currently under any restriction or on probation for reasons related to CDS by a Health Occupations Board, a State or federal agency? **□Yes □ No**

F. Has there been adverse action taken against your Professional license in another state/country? **□Yes □ No**

G. Have you ever been convicted of a felony violation or a violation pertaining to your profession? **□Yes □ No**

If yes is the answer to any of the above questions, submit a detailed explanation and copies of pertinent/supporting documentation.

SIGNATURE:	DATE: / /	**Your signature attests to the fact that the information provided is accurate.**